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Mental Health and Resilience: Soldiers' Perceptions about Psychotherapy, Medications, and Barriers to Care in the United States Military

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14. ABSTRACT
Research has reported perceived barriers to care in military populations, but there have not been any studies to date that demonstrate the degree to which subjective barriers translate into lack of utilization. Moreover, studies of mental health service utilization have not examined patient beliefs and perceptions, instead focusing on characteristics such as race, gender, and socio-demographic variables. To our knowledge there have not been any systematic investigations into what soldiers believe about mental health treatment.
Results from this study will provide the mental health community with valuable information about 1) Barriers to receiving mental health care in symptomatic individuals; 2) The effects those barriers have on health care utilization; 3) Beliefs about mental health and treatment preferences that can inform education and treatment planning efforts; 4) Factors associated with psychological resilience and how those factors affect healthcare utilization. We collected survey data from 550 participants at Fort Drum. Barriers to care, specifically negative beliefs about psychotherapy, were found to contribute to decreased healthcare utilization, especially in Service Members with severe PTSD sypmtoms. This has potential relevance to promote educational materials that directly address these beliefs. It also suggests that treatment may be modified to include interventions specifically addressing negative beliefs and ruptures in therapuetic alliance, which could account for early termination.

15. SUBJECT TERMS
Resilience, Barriers to Care, Combat Deployment Adjustment

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INTRODUCTION

An initial survey of soldiers returning from Afghanistan and Iraq found that 11.2 -17.1% met screening criteria for a mental disorder, yet only 23-40% of those with a positive screen were interested in receiving mental health care (Hoge et al, 2004). Research has reported perceived barriers to care in military populations, but there have not been any studies to date that demonstrate the degree to which subjective barriers translate into lack of utilization. Moreover, studies of mental health service utilization have not examined patient beliefs and perceptions, instead focusing on characteristics such as race, gender, and socio-demographic variables. To our knowledge there have not been any systematic investigations into what soldiers believe about mental health treatment. Moreover, there have been no studies examining how beliefs about treatment and etiology of psychological disorders relate to seeking professional help at a military mental health clinic and to general healthcare utilization. The intended scope of this award was to collect data from a sample (n= 3600) of Active Duty Service Members from the 10th Mountain Light Infantry Division, Fort Drum NY, who recently returned from a deployment to Iraq or Afghanistan.

Andersen (1995) presents a three-factor theoretical framework for the analysis of factors which potentially contribute to care utilization: 1) Predisposing factors such as patient demographics of race, gender, and age; 2) Enabling factors such as positive or negative beliefs, biases, and social influences (both positive and negative), and; 3) Need factors such as illness severity.

Objectives:

1) Compare and contrast symptomatic soldiers who do utilize mental health services with symptomatic soldiers who do not utilize mental health services (e.g. differences in symptoms severity, beliefs and perceived barriers to care, psychological resilience). Clarify the nature of behavioral health 'utilization' by differentiating between psychotherapy and medication therapy.
2) Analyze the relationship between beliefs about mental health (subjective barriers to care, psychotherapy, medication, and attributions) and mental healthcare utilization.
3) Determine the relationship between mental health resilience (psychological resilience, unit support, post-deployment support) and use of mental health services.

Hypothesis 1: Psychopathology will be associated with decreased mental healthcare utilization.
Hypothesis 2: Scores on measures of support/resilience variables will be negatively associated with healthcare utilization after controlling for demographic and psychopathology variables associated with healthcare utilization.
Hypothesis 3: Perceptions of stigma, barriers to care, and beliefs about mental healthcare will be negatively associated with healthcare utilization.

BODY

Procedure

All soldiers returning from deployment receive a Post-Deployment Health Assessment during their first week home. Due to the distractions associated with homecomings following stressful deployments, data collection opportunities during the initial stages of demobilization are limited. The MEDDAC at Fort Drum has implemented a re-screening process that occurs 90-180 days after soldiers return home. After the soldier has been home for at least 90 days, a secure personal internet account (Army Knowledge On-line) makes the Post-Deployment Health Reassessment (PDHRA), available to each soldier. By providing a 3-6 month post-deployment window for the reassessment of health, the soldier's first few months at home are dedicated to time with family and a return to relative normalcy. Additionally, symptoms of combat stress are often delayed and masked by the relief and euphoria of returning home. A 3-6 month delay in conducting the PDHRA is intended to facilitate more accurate insight and self-evaluation of potential problems and needs. A similar approach (assessing soldiers 3-4 months after their return) was also used by Hoge et al (2004) in a large sample (N = 6000+) descriptive study of troops returning from OIF and OEF.

After completing the PDHRA on-line, soldiers waited approximately 1-3 months, depending on their unit's training calendar, before being scheduled for the Battle Mind II debrief. Informed Consent and our Beliefs and Barriers to Care research survey took place approximately 6 months following soldiers' return from deployment. With permission of the brigade commanders, announcements about this study were made at the unit level. Dr Benham and associates were given an hour to present the study opportunity to the units, answer questions, give informed consent and then administer the assessment battery. The Beliefs and Barriers to Care battery took approximately 30 minutes for each participant (see 'Method' section for details of each questionnaire). The assessment battery was administered as a paper-and-pencil measure, distributed to participants at the unit or company level in a large classroom setting.

Medical healthcare utilization data for each soldier was tracked with pre-existing software currently used by the MEDDAC staff. Clinic visits and return appointments were tracked via the Computerized Health Care System (CHCS) and the Integrated Clinical Database (ICDB). Only information pertaining to clinic visits and appointments were tracked by the research team.

Measures

The following measures were administered in the Beliefs and Barriers to Care survey:

1. PREDISPOSING FACTORS
    - **a.** Demographic data was accessed from each participant's Post-Deployment Health Reassessment (PDHRA) form filled out immediately prior to participation in the survey. As race and ethnicity are not asked as part of the PDHRA, we included assessment items asking each participant to identify themselves accordingly. The varaibles AGE, GENDER, RACE, and MARITAL STATUS were used for this analysis.

2. ENABLING FACTORS
    a. Barriers to Care Inventory: An 11-item self-report assessment of obstacles that prevent or dissuade individuals from seeking mental health treatment. This measure assesses pressures such as lack of trust, stigma, stereotypes, finances, time-off from work, and psychological insecurity. Comparison data available for $N = 6153$ combat veterans, including stratified samples of soldiers who met screening criteria for psychopathology ($n = 731$) and those who did not ($n = 5422$) following deployments to Iraq and Afghanistan (Hoge et al., 2004). We derived a measure of instrumental stigma, beliefs about finances, time-off from work, etc., and psychological stigma, concerns about trust, opinions of others, and stereotypes.

    b. Beliefs about Psychotropic Medications & Psychotherapy: A 14-item Likert scale assessment of personal beliefs about psychotropic medication and psychotherapy. Scale items were derived via confirmatory factor analysis of ($n = 232$) participants enrolled in the Collaborative Care for Anxiety and Panic (CCAP) study comprising community care clinics in Seattle, San Diego, and Los Angeles. Six scale items assess beliefs about medications, with the remaining eight items assessing patient beliefs about psychotherapy. Cronbach's alpha's for the medication and psychotherapy sub-scales were .71 and .82 respectively, indicating acceptable to good internal consistency (Bystritsky et al., 2005).

    c. Connor-Davidson Resilience Scale (CD-RISC): The CD-RISC was developed as a self-report assessment of psychological resilience. The scale comprises 25 Likert scale items that assess five orthogonal resilience factors, with five items per factor (Factor 1 = personal competence; Factor 2 = trust and tolerance of negative affect; Factor 3 = acceptance of change; Factor 4 = control; Factor 5 = spiritual influences). Psychometric data was obtained from multiple samples including non-help seeking ($n = 577$), psychiatric outpatients ($n = 43$), primary care patients ($n = 139$), and subjects enrolled in a PTSD treatment study ($n = 44$). The CD-RISC was shown to have high test-retest reliability ($r = .87$) and good internal consistency (Cronbach's alpha = .89). Results also revealed the CD-RISC to be sensitive to the effects of treatment, with greater therapeutic improvement marked by proportionate increases in resilience (Connor & Davidson, 2003).

    d. Unit Support Scale: A 12 item Likert scale assessment of nature of professional relationships and cohesion between the soldier and his/her unit. Questions on this measure include "my unit was like a family to me," "I could go to most people in my unit for help when I had a personal problem," and "my superiors made a real attempt to treat me as a person." This measure is also part of the DRRI and demonstrated good internal consistency (Cronbach's alpha = .94; King, King, & Vogt, 2003).

3. NEED FACTORS
    a. Posttraumatic Stress Checklist-Military (PCL-M): The PCL-M is a 17 item self-report assessment of PTSD symptom severity developed by the National Center for PTSD. The military version of the PCL is keyed to stressful military experiences, and corresponds to 17 items directly adapted from the DSM-IV PTSD criteria. Psychometric data was obtained from veterans of the Vietnam War as well as the Persian Gulf War. The PCL-M demonstrated good internal consistency (Cronbach's alpha = .96 and .97 respectively). Test-retest reliability over a 2-3 day period was r = .96 (Weathers & Ford, 1996).

Results

Demographics

We anticipated our data collection of 3600 Service Members to occur in Spring of 2011. However, two weeks prior to the collection date, the BCT withdrew their involvement in the study. We then began scheduling for a summer data collection time with another BCT. Unfortunately, an incident on Post with an un-related third party research group that was also collaborating with Dr. Benham caused a shut down of all research activities at Fort Drum. This research embargo caused a 6-month delay while we awaited decisions from Fort Drum JAG and Acting Division Surgeon regarding our ability to conduct this research. The decision was reached that the third party research team needed to obtain a tasking from FORSCOM to conduct their research at Fort Drum. In the winter of 2011, we began this process for our protocol. Dr. Southwick spoke with Division about the protocol in the hopes of regaining Division and BCT support that would remove the need for the tasking. At that time, the leadership that was originally in place was no longer stationed at Fort Drum by Spring of 2012. Instead, we were permitted to offer participation to the 2nd Battalion 22nd Regiment, a much smaller division (n=800) of Soldiers within the 1st Brigade Combat Team. In April of 2012, we presented the survey to the division and collected data from 550 Service Members (a 68.75% response rate). After meeting with our lead statistical consultant, we believed the primary aims and hypotheses for this protocol could still be addressed with appropriate statistical power, particularly by utilizing the Andersen (1995) model which allows us to test all 3 hypotheses in one statistical test. The most significant loss was an exploratory descriptive analysis of the nature of patient flow and retention at Fort Drum MEDDAC. Our colleagues at Fort Drum felt that this analysis was no longer as important given changes in MEDDAC services in recent years. Therefore, we now report on the results of our sample at N=550.

The age range in our Infantry Regiment sample was between 18-48, with a mean of 25.38 (SD= 5.49). Approximately 90% of our sample was male, 76% Caucasian non-Hispanic, and 50% reported they were married. 83% of our sample held ranks between E1-E4 (junior enlisted), 15% held ranks between E5-E7 (senior enlisted) and 3% were officers.

Critically, when taking a PCL symptom severity score >50 as well as establishing criteria for clusters B, C, and D, approximately 11% of our sample met criteria for PTSD

by self report. In this manner, the characteristics of our sample are consistent with other survey studies of active duty demographics and rates of PTSD.

Utilization of mental healthcare services ranged from 1 to 33 sessions. In an extension of the healthcare utilization profile of symptomatic Service Members reported by Hoge et al (2004), 65% of our sample who met criteria for PTSD were untreated. Further, in consideration of Service Members who may be experiencing partial PTSD symptoms (PCL score between 30-49), 70% were untreated. 33% of those seeking treatment only completed an initial intake interview. An additional 33% completed 4 sessions of cognitive-based PTSD treatment, an amount of treatment considered by MEDDAC to be a "usual dose" (Benham, personal communication).

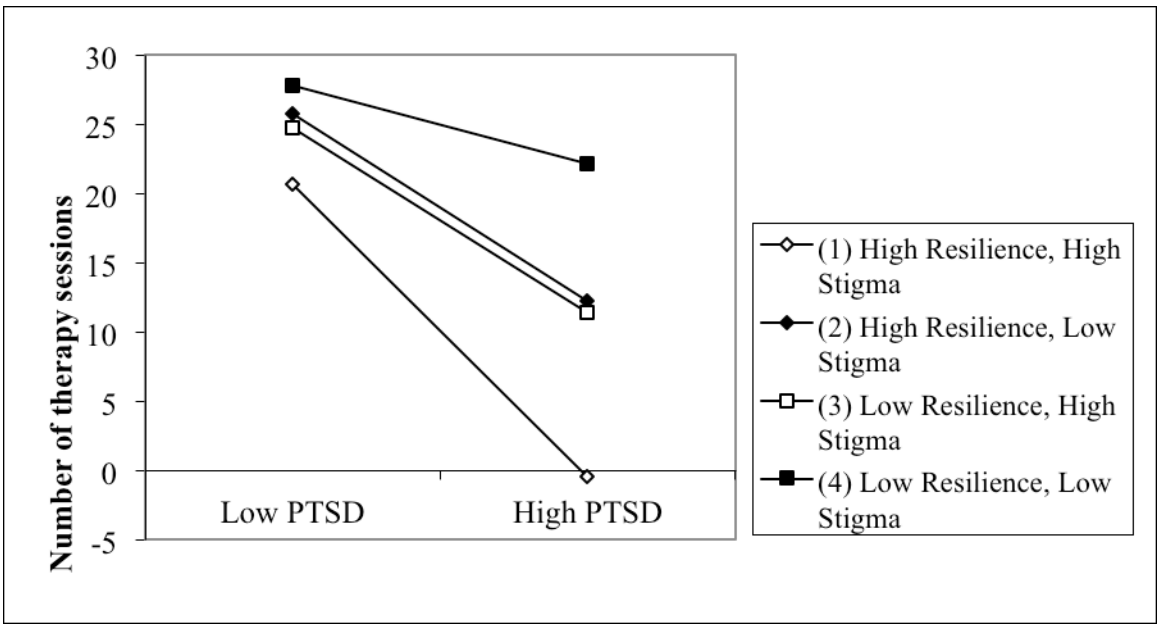
Hypothesis Tests

To test our hypotheses within the Andersen (1995) framework, we conducted two stages of heirarchical regressions. In the first stage, a full model was tested, which included step 1 PREDISPOSING FACTORS (Age, Gender, Race, and Martial Status), Step 2 ENABLING FACTORS (Negative beliefs about psychotherapy, Negative beliefs about psychiatric medication, Instrumental Stigma, Psychological Stigma, Unit Support, and Resilience), and Step 3 NEED FACTORS (PCL-M total score). Factors which did not have a significant ANOVA and F change statistic were not included in the second stage analysis, which tested only those variables with a significant Beta value as well as all possible interactions.

In the first stage analysis, the PREDISPOSING FACTOR failed to significantly account for variance in the total number of therapy sessions, $F(4,546) = 1.15$, $p = .34$. The ENABLING and NEED FACTORS each accounted for a significant amount of increased variance, $F(6, 541) = 4.52$, $p<.0001$, $F(2,539) = 3.76$, $p <.025$, respectively, with a significant model $F(12, 546) = 3.35$, $p<.0001$.

In our second stage analysis, our final model consisted of three remaining variables: Negative beliefs about psychotherapy, Resilience, and PTSD symptom severity (entered as Step 1), as well as all possible 2-way and 3-way interactions (entered as Step 2). The total model was significant $F(7, 535) = 19.97$, $p <.0001$, with the interaction terms accounting for a significant increase in variance explained, F change $(4, 546) = 14.74$, $p<.0001$, Adjusted $R^2 = .201$. All main effects were significant ($p<.0001$) and the 3-way interaction term was significant as well, $t=2.26$, $p<.024$.

FIGURE 1: The Influence of Resilience, Negative Stigma regarding Psychotherapy, and PTSD symptom severity on PTSD treatment length in an Infantry Regiment.



As Figure 1 indicates, greater stigma and higher levels of reported resilience were each related to fewer sessions attended. This effect was more pronounced in Service Members with higher PTSD (+1 SD above the mean) than those with lower PTSD (-1 SD below the mean). Indeed, Service Members with high PTSD symptom severity who considered themselves highly resilient and with a strong negative opinion about psychotherapy did not engage treatment at all, on average.

Discussion

Consistent with past research (Hoge et al, 2004) we found PTSD symptomatic Service Members remain reluctant to engage clinical services for treatment. We expanded on past research by utilizing a theoretical model which allowed us to consider a broad panel of potential contributors to treatment seeking. As with most studies of Active Duty and recently returned Veteran healthcare utilization, we found support for only Enabling and Need-based factors. Importantly, we were able to consider stigma as three separate domains: instrumental, psychological, and negative beliefs about treatment. When evaulated in this manner, we found that increased negative beliefs specifically about psychotherapy contributed to decreased care utilization. We also found that resilience contributed to decreased utilization, as predicted. These findings hold promise for improvement in that negative beliefs about psychotherapy may be modified by educational materials aimed at enlisted Service Members.

We also found that increased PTSD symptom severity was associated with decreased utilziation, a factor which moderated the impact of negative beliefs and resilience factors. The Behavioral MEDDAC at Fort Drum uses a version of Cognitive Processing Therapy (an evidence-based form of psychotherapy)which directly engages the patient's negative thoughts about a trauma and exposes the patient to distressing events. It is possible that, with highly symptomatic patients, this intense treatment may contribute to early termination due to distress avoidance.

There were several important limitations to consider with this survey study. PTSD diagnosis was estimated via a survey and not a diagnostic interview. We did not

assess other possible psychiatric sequelae of traumatic stress exposure, including depression, anger, or alcohol mis-use. Also, while we did not find any effects of Predisposing factors on health care utilization, we did not over-sample female Service Members or Service Members of racial and ethnic minorities to fully test these factors. As Infantry Regiments are largely a male-dominated position, it would be impractical for such an undertaking.

Another significant limitation of this study was the time it took to complete the award – originally conceived as a 24 month time period. The award inititated at Yale University in Fall 2008, where it took 2 months to receive IRB approval for this minimal risk survey and medical record study. HRPO then determined the study required approval from the Walter Reed IRB, as the study involved Active Duty personnel, during work hours on post, and required access to Army military medical records. Walter Reed approval took 15 months to obtain, primarily due to: a) difficulties getting the Yale team registered with Army IRBNet access to submit the protocol on behalf of Dr. Benham (the Army recognized PI); b) determining that VA Connecticut could NOT be engaged in the research. The Yale research team is housed at VA Connecticut and routinely passess all IRB materials through the VA Human Safety Subcommittee for approval of using the VA facilities. At the time, VA research policy was to mandate that all research required a VA consent form, which contradicted the Walter Reed IRB requirement for use of their consent form. After months of delibration and negotiation of a CRADA betweeen Yale and Walter Reed, the Yale protocol was amended to remove all action with VA Connecticut. We anticipated our data collection to occur in Spring of 2011. As stated above in the Results section, two weeks prior to the collection date, the BCT withdrew their involvement in the study. We then began scheduling for a summer data collection time with another BCT. Unfortunately, an incident on Post with an un-related third party research group that was also collaborating with Dr. Benham caused a shut down of all research activities at Fort Drum. This research embargo caused a 6-month delay while we awaited decisions from Fort Drum JAG and Acting Division Surgeon regarding our ability to conduct this research. The decision was reached that the third party research team needed to obtain a tasking from FORSCOM to conduct their research at Fort Drum. In the winter of 2011, we began the FORSCOM process for our protocol. Dr. Southwick spoke with Division about the protocol in the hopes of regaining Division and BCT support that would remove the need for the tasking. At that time, the leadership that was originally in place was no longer stationed at Fort Drum by Spring of 2012. Instead, we were permitted to offer participation to the 2nd Battalion 22nd Regiment, a much smaller division (n=800) of Soldiers within the 1st Brigade Combat Team. In April of 2012, we presented the survey to the division and collected data from 550 Service Members. After meeting with our lead statistical consultant, we believed the primary aims and hypotheses for this protocol could still be addressed with appropriate statistical power by using modeling techniques more appropriate for the current sample size. The most significant loss was an exploratory descriptive analysis of the nature of patient flow and retention at Fort Drum MEDDAC. Our colleagues at Fort Drum felt that this analysis was no longer as important given changes in MEDDAC services in recent years. The study was then closed to enrollment and started the longitudinal healthcare utilization data collection phase, which ended in May, 2013. A No Cost Extension was submitted to complete the project by September, 2013, however, there were unforseen difficulties with the No Cost

Extension Request. Originally, we had proposed that personnel at Fort Drum would be hired to enter the medical record data. It was determined by Fort Drum JAG that such arrangements were not permitted of DoD employees. Our Yale Research Assistant, Ms. Alicia Christensen, held several of the pre-requisites for this position, including: IRB approval and trainings, a valid CAC card as per her WOC position at the VA Connecticut Healthcare System, and familiarity with the protocol. When the NCE was finally granted in late Spring of 2013, we began the process of having her cleared to access the medical record computer software system at Fort Drum (the AHLTA system). Her permission was granted and data collection began In September 2014, a final 6-month No Cost Extension was granted to complete data collection, statistical analysis, and report writing.

In Fall of 2011, we pursued conducting this survey at another site (Ft. Bragg) with another ongoing collaborator. However, the protocol would be sufficiently disparate from the survey content used with the infantry at Fort Drum and we discontinued our efforts in pursuing this matter for the award purposes.

KEY RESEARCH ACCOMPLISHMENTS

- After 17 months of review, all local and military IRB approvals obtained.
- Survey collection (n=550) completed in 3 month time period.
- Medical record longitudinal data collection completed in 2 month time period, over a 6 month time frame.
- Key findings indicate: 1) Service Members with strong negative beliefs about psychiatric medications decreases length of treatment; 2) Greater reported resilience decreases length of treatment, and; 3) Increased PTSD symptom severity exacerbates these effects.

REPORTABLE OUTCOMES

1. Whereas we collected a smaller sample than originally proposed, we had sufficient statistical power to complete the project.
2. Intention to submit manuscript for publication in peer-reviewed scientific journal, Winter 2015.
3. Intention to present data at conference in 2015.
4. This award also funded several personnel, including the effort of the PI, Dr. Steven Southwick, and Co-Investigator, Dr. Deane Aikins. Research Assistants Jessica Jordan and Alicia Christensen Roy, and statistician Ralitza Gueorguieva were also funded for their efforts.

CONCLUSIONS

This research addresses important issues regarding Service Members' perceptions of barriers to care, resilience, and health care utilization. We collected a smaller sample of surveys then originally planned. This study underscores the need to improve coordination between civilian academic IRBs, military IRBs and Active Duty military bases.

Barriers to care, specifically negative beliefs about psychotherapy, were found to contribute to decreased healthcare utilization, especially in Service Members with severe PTSD sypmtoms. This has potential relevance to promote educational materials that directly address these beliefs. It also suggests that treatment may be modified to include interventions specifically addressing negative beliefs and ruptures in therapuetic allianc based on erroneous assumptions regarding treatment, which could account for early termination.

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FORT DRUM RESILIENCE PROJECT

1. Today's Date ☐☐ / ☐☐ / ☐☐☐☐
   mm dd yyyy

2. Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. First Name ☐☐☐☐☐☐☐☐☐☐ I. ☐

4. Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
   mm dd yyyy

5. Last 4 Social Security Number ☐☐☐☐

6. Ethnicity: Hispanic or Latino ○ Yes ○ No

7. Race: (check one or more)
   - ○ American Indian or Alaska Native
   - ○ Asian
   - ○ Black or African American
   - ○ Native Hawaiian or Other Pacific Islander
   - ○ White

FORT DRUM RESILIENCE PROJECT

Section A: Perceived Barriers to Care Assessment

Rate how each of the possible concerns might affect your decision to receive mental health counseling or services if you ever had a problem.

	Strongly DISAGREE	DISAGREE	UNSURE NEITHER AGREE NOR DISAGREE	AGREE	Strongly AGREE
1. I don't trust mental health professionals.	○	○	○	○	○
2. I don't know where to get help.	○	○	○	○	○
3. I don't have adequate transportation.	○	○	○	○	○
4. It is difficult to schedule an appointment.	○	○	○	○	○
5. There would be difficulty getting time off work for treatment.	○	○	○	○	○
6. Mental health care costs too much money.	○	○	○	○	○
7. It would be too embarrassing.	○	○	○	○	○
8. It would harm my career.	○	○	○	○	○
9. Members of my unit might have less confidence in me.	○	○	○	○	○
10. My unit leadership might treat me differently.	○	○	○	○	○
11. My leaders would blame me for the problem.	○	○	○	○	○
12. I would be seen as weak.	○	○	○	○	○
13. Mental health care doesn't work.	○	○	○	○	○
14. Psychotherapy is not effective for most people.	○	○	○	○	○
15. Being in therapy is a sign of weakness.	○	○	○	○	○
16. Therapy can help individuals overcome stressful life events.	○	○	○	○	○
17. Anxiety and depression symptoms can usually be improved with medication.	○	○	○	○	○
18. Medications for anxiety and depression do not help a person cope better.	○	○	○	○	○
19. Most medications for anxiety and depression are highly addictive.	○	○	○	○	○

Section B: Beliefs About Psychotherapy

Please indicate the degree to which you personally AGREE or DISAGREE with each statement.

	Strongly DISAGREE	DISAGREE	Neutral	AGREE	Strongly AGREE
1. Therapy is ineffective for most people.	O	O	O	O	O
2. Therapy patients are wasting money.	O	O	O	O	O
3. Therapy often harms the patient's relationships with other people.	O	O	O	O	O
4. Being in therapy is a sign of weakness.	O	O	O	O	O
5. Therapy offers patients new and beneficial perspectives.	O	O	O	O	O
6. Therapy is unhealthy because patients usually become dependent on their relationships with the therapist.	O	O	O	O	O
7. Therapy can help individuals overcome stressful life events.	O	O	O	O	O
8. Therapy can be a healthy experience for anyone.	O	O	O	O	O

Section C: Beliefs About Medications

Please indicate the degree to which you personally AGREE or DISAGREE with each statement.

	Strongly DISAGREE	DISAGREE	Neutral	AGREE	Strongly AGREE
1. Anxiety and Depression symptoms can usually be improved with medication.	O	O	O	O	O
2. Medications are an important part of the treatment of anxiety and depression.	O	O	O	O	O
3. Medications for anxiety and depression can help a person feel better physically.	O	O	O	O	O
4. People with anxiety should avoid taking medications to help their anxious problems.	O	O	O	O	O
5. Medications for anxiety and depression do not help a person cope better.	O	O	O	O	O
6. Most medications for anxiety and depression are highly addictive.	O	O	O	O	O

Section D: Connor- Davidson Resilience Scale (CD-RISC)

Please indicate how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

	Not At All True	Rarely True	Sometimes True	Often True	True Nearly All the Time
1. I am able to adapt when changes occur.	○	○	○	○	○
2. I have at least one close and secure relationship which helps me when I am stressed.	○	○	○	○	○
3. When there are no clear solutions to my problems, sometimes fate or God can help.	○	○	○	○	○
4. I can deal with whatever comes my way.	○	○	○	○	○
5. Past successes give me confidence in dealing with new challenges and difficulties.	○	○	○	○	○
6. I try to see the humorous side of things when I am faced with problems.	○	○	○	○	○
7. Having to cope with stress can make me stronger.	○	○	○	○	○
8. I tend to bounce back after illness, injury, or other hardships.	○	○	○	○	○
9. Good or bad, I believe that most things happen for a reason.	○	○	○	○	○
10. I give my best effort, no matter what the outcome may be.	○	○	○	○	○
11. I believe I can achieve my goals, even if there are obstacles.	○	○	○	○	○
12. Even when things look hopeless, I don't give up	○	○	○	○	○
13. During times of stress/crisis, I know where to turn for help.	○	○	○	○	○
14. Under pressure, I stay focused and think clearly.	○	○	○	○	○
15. I prefer to take the lead in solving problems, rather than letting others make all the decisions	○	○	○	○	○
16. I am not easily discouraged by failure.	○	○	○	○	○
17. I think of myself as a strong person when dealing with life's challenges and difficulties.	○	○	○	○	○
18. I can make unpopular or difficult decisions that affect other people, if it is necessary.	○	○	○	○	○
19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger	○	○	○	○	○
20. In dealing with life's problems, sometimes you have to act on a hunch, without knowing why.	○	○	○	○	○
21. I have a strong sense of purpose in life.	○	○	○	○	○
22. I feel in control of my life.	○	○	○	○	○
23. I like challenges.	○	○	○	○	○
24. I work to attain my goals, no matter what roadblocks I encounter along the way.	○	○	○	○	○
25. I take pride in my achievements.	○	○	○	○	○

Section E: FLOVQ

*Please indicate how much **distress**, **anxiety**, or **fear** you would feel with each of the following experiences using the 0-8 scale below,*
0 = no distress, anxiety, or fear [----------] 8 = extreme distress, anxiety, or fear.
Please rate each item even if you would not actually allow yourself to have that experience.

1. How much distress/anxiety/fear do you experience when you experience **drowsiness**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

2. How much distress/anxiety/fear do you experience when **zoning or spacing out**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

3. How much distress/anxiety/fear do you experience **not being wide awake**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

4. How much distress/anxiety/fear do you experience **feeling disconnected from yourself**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

5. How much distress/anxiety/fear do you experience **"missing" things in conversations**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

6. How much distress/anxiety/fear do you experience **being in a daze**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

7. How much distress/anxiety/fear do you experience **becoming drowsy after taking an antihistamine or related drugs**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		Mild distress/ fear/ anxiety		Moderate distress/ fear/anxiety		Severe distress/ fear/anxiety		Extreme distress/ fear/anxiety

Section E: FLOVQ continued

8. How much distress/anxiety/fear do you experience **not being fully alert**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

9. How much distress/anxiety/fear do you experience when **daydreaming**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

10. How much distress/anxiety/fear do you experience **nodding off during the day**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

11. How much distress/anxiety/fear do you experience when **experiencing wooziness**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

12. How much distress/anxiety/fear do you experience **not being fully aware of your surroundings**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

13. How much distress/anxiety/fear do you experience when experiencing **mental exhaustion**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

14. How much distress/anxiety/fear do you experience when experiencing **fatigue from lack of sleep**?

0	1	2	3	4	5	6	7	8
No distress/ fear/ anxiety		**Mild** distress/ fear/ anxiety		**Moderate** distress/ fear/anxiety		**Severe** distress/ fear/anxiety		**Extreme** distress/ fear/anxiety

Section F: PCL-M

Below is a list of problems and complaints that people sometimes have in response to stressful military experiences. Please read each one carefully, then fill in the circle that indicates how much you have been bothered by that problem <u>in the PAST MONTH</u>.

In the PAST MONTH, have you been bothered by...	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing *memories*, *thoughts*, or *images* of a stressful military experience from the past?	○	○	○	○	○
2. Repeated, disturbing *dreams* of a stressful military experience from the past?	○	○	○	○	○
3. Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?	○	○	○	○	○
4. Feeling *very upset* when *something reminded* you of a stressful military experience from the past?	○	○	○	○	○
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful military experience from the past?	○	○	○	○	○
6. Avoiding *thinking about or talking about* your stressful military experience or avoiding *having feelings* related to it?	○	○	○	○	○
7. Avoiding *activities* or *situations* because they reminded you of your stressful military experience?	○	○	○	○	○
8. Trouble *remembering important parts* of a stressful military experience?	○	○	○	○	○
9. *Loss of interest* in activities that you used to enjoy?	○	○	○	○	○
10. Feeling *distant* or cut off from other people?	○	○	○	○	○
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	○	○	○	○	○
12. Feeling as if your *future* somehow will be cut short?	○	○	○	○	○
13. Trouble *falling* or *staying* asleep?	○	○	○	○	○
14. Feeling *irritable* or having angry *outbursts*?	○	○	○	○	○
15. Having *difficulty* concentrating?	○	○	○	○	○
16. Being "*super alert*" or watchful or on guard?	○	○	○	○	○
17. Feeling *jumpy* or *easily* startled?	○	○	○	○	○

Section G: PDAQ

Please indicate your level of agreement/disagreement with each of the following sentences.

1. I believe that persons with Posttraumatic Stress Disorder (PTSD) are to blame for their problems.

1	2	3	4	5	6	7
Agree						Disagree

2. I think that persons with psychosis are likely to benefit from counseling.

1	2	3	4	5	6	7
Agree						Disagree

3. I believe that persons with depression are to blame for their problems.

1	2	3	4	5	6	7
Agree						Disagree

4. I feel sorry for persons with depression.

1	2	3	4	5	6	7
Agree						Disagree

5. I think that persons with depression will recover.

1	2	3	4	5	6	7
Agree						Disagree

6. I feel sorry for persons with PTSD.

1	2	3	4	5	6	7
Agree						Disagree

7. I think that persons with PTSD will recover.

1	2	3	4	5	6	7
Agree						Disagree

8. I avoid persons with psychosis.

1	2	3	4	5	6	7
Agree						Disagree

9. I think that persons with PTSD are likely to benefit from counseling.

1	2	3	4	5	6	7
Agree						Disagree

Section G: PDAQ continued

10. I believe that persons with psychosis are likely to benefit from medicine.

1	2	3	4	5	6	7
Agree						Disagree

11. I think that persons with psychosis will recover.

1	2	3	4	5	6	7
Agree						Disagree

12. I avoid persons with depression.

1	2	3	4	5	6	7
Agree						Disagree

13. I believe that persons with depression are likely to benefit from medicine.

1	2	3	4	5	6	7
Agree						Disagree

14. I think that persons with depression are likely to benefit from counseling.

1	2	3	4	5	6	7
Agree						Disagree

15. I believe that persons with PTSD are likely to benefit from medicine.

1	2	3	4	5	6	7
Agree						Disagree

16. I avoid persons with PTSD.

1	2	3	4	5	6	7
Agree						Disagree

17. I believe that persons with psychosis are to blame for their problems.

1	2	3	4	5	6	7
Agree						Disagree

18. I feel sorry for persons with psychosis.

1	2	3	4	5	6	7
Agree						Disagree

SECTION H: UNIT SUPPORT

The statements below are about your relationships with other military personnel while you were deployed. Please read each statement and describe how much you agree or disagree by filling in the circle that best fits your answer.

	Strongly DISAGREE	Somewhat DISAGREE	NEITHER AGREE NOR DISAGREE	Somewhat AGREE	Strongly AGREE
1. My unit was like family to me.	○	○	○	○	○
2. I felt a sense of camaraderie between myself and other soldiers in my unit.	○	○	○	○	○
3. Members of my unit understood me.	○	○	○	○	○
4. Most people in my unit were trustworthy.	○	○	○	○	○
5. I could go to most people in my unit for help when I had a personal problem.	○	○	○	○	○
6. My commanding officer(s) were interested in what I thought and how I felt about things.	○	○	○	○	○
7. I was impressed by the quality of leadership in my unit.	○	○	○	○	○
8. My superiors made a real attempt to treat me as a person.	○	○	○	○	○
9. The commanding officer(s) in my unit were supportive of my efforts.	○	○	○	○	○
10. I felt like my efforts really counted to the military.	○	○	○	○	○
11. The military appreciated my service.	○	○	○	○	○
12. I was supported by the military.	○	○	○	○	○

SECTION I: RELATIONSHIPS WITHIN UNIT

The next set of questions is also about your relationships with other military personnel while deployed. Please describe how often you experienced each circumstance by filing in the circle that best fits your answer.

While I was deployed, unit leaders or other unit members:	Never	Once or Twice	Sometimes	Many Times
1. …treated me in an overly critical way.	○	○	○	○
2. …behaved in a way that was uncooperative when working with me.	○	○	○	○
3. ... treated me as if I had to work harder than others to prove myself.	○	○	○	○
4. ... questioned my abilities or commitment to perform my job effectively.	○	○	○	○
5. ... acted as though my mistakes were worse than others.	○	○	○	○
6. …tried to make my job more difficult to do.	○	○	○	○
7. ..."put me down" or treated me in a condescending way.	○	○	○	○
8. ... gossiped about my sex life or spread rumors about my sexual activities.	○	○	○	○
9. ...made crude and offensive sexual remarks directed at me, either publicly or privately.	○	○	○	○
10. …offered me some sort of reward or special treatment to take part in sexual behavior.	○	○	○	○
11. …threatened me with some sort of retaliation for not being sexually cooperative (for example, the threat of a negative review, physical violence, or to ruin my reputation).	○	○	○	○
12. …made unwanted attempts to stroke or fondle me (for example, stroking my leg or neck).	○	○	○	○
13. ...made unwanted attempts to have sex with me.	○	○	○	○
14. ...forced me to have sex.	○	○	○	○

Section J: DEPLOYMENT CONCERNS

The statements below are about the amount of danger you felt you were exposed to while you were deployed. Please read each statement and describe how much you agree or disagree with each statement by filling the circle in the column that best fits your answer.

During my deployment ...	Strongly DISAGREE	Somewhat DISAGREE	NEITHER AGREE NOR DISAGREE	Somewhat AGREE	Strongly AGREE
1. I thought I would never survive.	○	○	○	○	○
2. I felt safe.	○	○	○	○	○
3. I was extremely concerned that the enemy would use nuclear, biological, chemical agents (NBCs) against me.	○	○	○	○	○
4. I felt that I was in great danger of being killed or wounded.	○	○	○	○	○
5. I was concerned that my unit would be attacked by the enemy.	○	○	○	○	○
6. I worried about the possiblility of accidents (for example, friendly fire or training injuries in my unit).	○	○	○	○	○
7. I was afraid I would encounter a mine or booby trap.	○	○	○	○	○

Thank you for completing this survey.